

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09777

CERTIFICATE OF DEATH

09776

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN Tb 12 Hrs.		d. STREET ADDRESS 07-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES TIMOTHY ATWELL		4. DATE OF DEATH July 30 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1966
9. AGE (In years lost birthday) yrs. 36		IF UNDER 1 YEAR Months Days Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Danny E. Atwell		14. MOTHER'S MAIDEN NAME Oudia Thacker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Danny E. Atwell		Address Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7625 DUE TO (b) Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Pre ventricular 18 hrs. 1 hr.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 29, 1966, to July 30, 1966, that (I) (we) last saw the deceased alive on July 30, 1966, and that death occurred at 10:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera, M.D.		22b. DATE SIGNED 7/30/66	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera, M.D.		22d. ADDRESS E. Main St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 2, 1966	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	23d. LOCATION (City or Town) (County) (State) Elkton, Md.
24. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE AUG 2 1966	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2552

0852

CERTIFICATE OF DEATH

09778

09777

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 2 yrs. 9 Mon.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Westmoreland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital				d. STREET ADDRESS 296 E. Main				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE MAE BARNETTE						4. DATE OF DEATH Month JULY Day 18 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-75		9. AGE (In years lost birthday) yrs. 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Springdale, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Couch (Dec) Penna.						14. MOTHER'S MAIDEN NAME Louise (Maiden Name Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 478-18-70-33		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Carcinoma Of Left Breast With Metastasis To Pleura (Post Operative Status) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 3 to 6 Days 1 Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Generalized								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 10-29- , 19 63 to 7-18 , 19 66 , and that death occurred at 12:20 AM , from causes and on the date stated above.									
22a. SIGNATURE Ben Rothfeld				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-18-66			
22c. PHYSICIAN'S NAME (Type) BEN ROTHFELD, M.D.				22d. ADDRESS VAH, PERRY POINT, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-21-1966		23c. NAME OF CEMETERY OR CREMATORY Belington National Home, Belington, Va.		23d. LOCATION (City or town) (County) (State)			
24. FUNERAL DIRECTOR Lee A Patterson & Son, Perryville, Md				25a. REC'D BY REGISTRAR JUL 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201.

CERTIFICATE OF DEATH

097773

097778

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRYVILLE		c. LENGTH OF STAY IN lb 5 mos 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON		12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH, PERRY POINT, MARYLAND				d. STREET ADDRESS ROUTE 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLINTON, BROOKS				4. DATE OF DEATH Month Day Year JULY 4 19 66			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 5-3-94	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) HARFORD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME JAMES E. BROOKS	
13. FATHER'S NAME JAMES E. BROOKS				14. MOTHER'S MAIDEN NAME LAURA THOMPSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I				16. SOCIAL SECURITY NO. 218180612		17. INFORMANT VA HOSPITAL, PERRY POINT, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion and edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized				INTERVAL BETWEEN ONSET AND DEATH 1-3 days years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 2-7 , 19 66 , to 7-4 , 19 66 , that (1) (we) last saw the deceased alive on October 19, 1966 , and that death occurred at 12:00 , from causes and on the date stated above.							
22a. SIGNATURE Charles E. Lawson C. E. LAWSON				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-14-66	
22c. PHYSICIAN'S NAME (Type) C. E. LAWSON, MD.				22d. ADDRESS VAH, PERRY POINT, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7-7-66		23c. NAME OF CEMETERY OR CREMATORY CLARKS CHAPEL		23d. LOCATION (City or Town) (County) (State) KAITIA HARFORD MD	
24. FUNERAL DIRECTOR Charles Little TITLE FUNERAL HOME				25a. REC'D BY REGISTRAR 230 Baltimore Pike Bel Air, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09780					09779				
1. PLACE OF DEATH a. CDUNITY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton Rural c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Cecilton d. STREET ADDRESS 07-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mabel First L. Middle Burris Last			4. DATE OF DEATH July, Month 4, Day 19 66 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH October 14, 1901 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife. 10b. KIND OF BUSINESS OR INDUSTRY Home. 11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Andrew Leybold 14. MOTHER'S MAIDEN NAME Sarah Whitlock						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. Elwood H. Burris, 17. INFORMANT Cecilton, Md. 21913 Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH year						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery insufficiency 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 5						
21. I certify that (I) (this hospital) attended the deceased from August , 19 66 to 4 July, 66 , that (I) (we) last saw the deceased alive on 4 July , 19 66 , and that death occurred at 2:00 from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain 22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D.			22b. DATE SIGNED 5 July 66 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cecilton, Md. 21913			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July, 7, 1966 23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery 23d. LOCATION (City, town or county) (State) Galena, Kent Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows. Millington Md. ADDRESS			25a. REC'D BY REGISTRAR JUL 8 1966 25b. REGISTRAR'S SIGNATURE Charles Judge						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09781

CERTIFICATE OF DEATH

09780

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE TEXAS b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 2 yrs 8 mos 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Antonio		d. STREET ADDRESS 70-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carter Middle B. Last Butler		4. DATE OF DEATH Month July Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 6 90
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Tacketts Mill, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Umstead Butler (d)		14. MOTHER'S MAIDEN NAME Agnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 051-22-74-25	
17. INFORMANT VA Hospital Records Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable ventricular fibrillation, 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH sudden years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 11 21 63 , 19 7 24 66 , that the deceased died on 7 24 66 , and that death occurred at 5:20 p.m. from causes on and on the date stated above.			
22a. SIGNATURE Jerome W. Bergmann, M.D.		22b. DATE SIGNED 7 24 66	
22c. PHYSICIAN'S NAME (Type) JEROME W. BERGMANN, M.D.		22d. ADDRESS VAH Perry Point, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) 7/28/1966		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY LOLTON NAT. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25. REC'D BY REGISTRAR DATE AUG 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

118200

DEPARTMENT OF DEATH

18781

NAME

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

SEX

EDUCATION

RELIGION

HEIGHT

WEIGHT

CAUSE OF DEATH

AGE

DATE OF BURIAL

PLACE OF BURIAL

DETAILED DESCRIPTION OF DEATH

DETAILED DESCRIPTION OF BURIAL

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

<div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>09782</div> <div>09781</div> </div>									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
e. COUNTY Cecil MARYLAND					e. STATE Virginia b. COUNTY Arlington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 5Yrs. 6Months					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 5303 Sanger Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JULIUS First J. Middle CELANI Last			4. DATE OF DEATH 7 Month 6 Day 1966 Year						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-10-93		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ANTHONY CELANI					14. MOTHER'S MAIDEN NAME ROSA MORGANTI				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 231-20-5736		17. INFORMANT Address Hospital Records, VAH, Perry Point, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Hemorrhages of Lungs & Pelvis 978X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Multiple Fractures of Ribs, Pelvic Bones & Legs. DUE TO (c) Fall from 4th Story Window - BLDG. 23									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Tillman D. Johnson M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Tillman D. Johnson					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 7-11-66				
22c. NAME OF CEMETERY OR CREMATORY Arlington National					22d. LOCATION (City, town, or county) (State) Ft. Myers, Va.				
23. FUNERAL DIRECTOR R. Madison Mitchell ADDRESS Harold E. Smith					24a. REC'D BY REGISTRAR JUL 11 1966 DATE				
					24b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

09783

09782

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. STREET ADDRESS 506 Kerr Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lohring Middle J. Last Cooper		4. DATE OF DEATH Month July Day 17 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-94	9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR Months 17 Days 19 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Gore, Frederick Co., Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marshall Cooper		14. MOTHER'S MAIDEN NAME Fannie Gill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217-54-7525		17. INFORMANT VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Left Lung, Severe 4200 DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis, Generalized		INTERVAL BETWEEN ONSET AND DEATH 5 to 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that A.G. Gillis, M.D. attended the deceased from October 29, 1931 , to July 17, 1966 , and that death occurred at 2:10 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>A.G. Gillis M.D.</i>		22b. DATE SIGNED 7-18-66			
22c. PHYSICIAN'S NAME (Type) A.G. GILLIS, M.D.		22d. ADDRESS VA Hospital, Perry Point, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7-18-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron	
23d. LOCATION (City or Town) (County) (State) Winchester, Va. Fred. Va.					
24. FUNERAL DIRECTOR PENNINGTON & SON, HAVRE DE GRACE, MD.		25a. REC'D BY REGISTRAR DATE JUL 21 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

09784

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>P.O. Box 178</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital of Cecil County</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleanor M. Crouch</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-07</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>William Worthington</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Husband</u>		Address <u> </u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute competitive heart failure</u> DUE TO (b) <u>Post. pulmonary emboli, and post. RHD</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (1) (this hospital) attended the deceased from 6-13, 1966, to 7-2, 1966, that (2) (we) saw the deceased alive on 7-2, 1966, and that death occurred at 5:50 AM, from causes and on the date stated above.

22a. SIGNATURE <u>Jay S. Barnhart, Jr.</u>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>7-2-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Jay S. Barnhart, Jr. M.D.</u>	22d. ADDRESS <u>North East, Maryland</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>NEPER PARK, PENNA</u>
24. FUNERAL DIRECTOR <u>GRANT FUNERAL HOME</u>	ADDRESS <u>Box 24</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>JUL 8 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09785 CERTIFICATE OF DEATH 09784									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1 year 3 mos. 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Wheeling c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1008 Lind Street d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CLAIRE M. DAVIS			4. DATE OF DEATH July 8 1966		5. SEX Female				
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/9/1898		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Belmont, Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sheridan Davis (Deceased)					14. MOTHER'S MAIDEN NAME Ethel Gillespie (Deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WWII 277-12-0418		17. INFORMANT Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, Confluent and Terminal 4341 DUE TO (b) Aspiration Congestive Heart Failure DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 11, 1965, to July 8, 1966 , that the deceased died on July 8, 1966 and that death occurred at 7:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Joel Blancaflor					22b. DATE SIGNED 7-8-66			22c. PHYSICIAN'S NAME (Type) Joel Blancaflor, M.D.	
22d. ADDRESS VAH., Perry Point, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Holly Mem. Gardens		23d. LOCATION (City, town or county) (State) Belmont County, Ohio		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.					25a. REC'D BY REGISTRAR JUL 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
09786			CERTIFICATE OF DEATH		
09785					
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAZEL Middle LEE Last DILLOW			4. DATE OF DEATH Month July Day 4 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1912	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Wythe Co. Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William H. Stroupe			14. MOTHER'S MAIDEN NAME Minnie B. Bateman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 224-32-4653		17. INFORMANT Luther G. Dillow Address Box 48 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive heart failure DUE TO (b) Hypertensive and arteriosclerotic heart disease DUE TO (c) Diabetes mellitus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from 7-8 , 19 63 to 7-4 , 19 66 , that (1) (we) last saw the deceased alive on 6-23 19 66 , and that death occurred at 10:30 M, from causes and on the date stated above.					
22a. SIGNATURE Jay S. Barnhart Jr.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/5/66
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.			22d. ADDRESS 4 Mauldin Ave. North East, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/66		23c. NAME OF CEMETERY OR CREMATORY North East Methodist	
23d. LOCATION (City or Town) (County) (State) North East, Md.					
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Paul R. Rouch		25a. REC'D BY REGISTRAR JUL 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 14-2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Devine Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Galena d. STREET ADDRESS 14-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Arthur Middle Wallace Last Duhamell		4. DATE OF DEATH Month July Day 25 Year 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November, 4, 1882	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building Construction		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Duhamell		14. MOTHER'S MAIDEN NAME Lydia Hague				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 213-14-1171		17. INFORMANT Mrs. Katie Duhamell,		Address Galena, Md. 21635
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive bronchitis 5021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Galena, Kent Co; Md.
21. I certify that (I) (this hospital) attended the deceased from 2 Jan , 19 66 to 25 July 19 66 that (I) (we) last saw the deceased alive on 25 July 19 66 , and that death occurred at 4:40 PM , from the causes and on the date stated above.						
22a. SIGNATURE Wallace Obenshain		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 26 July 66		
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md. 21913				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July, 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery.		23d. LOCATION (City, town or county) (State) Galena, Kent Co; Md.
24. FUNERAL DIRECTOR Edward Fellows, Millington, Md.		ADDRESS Millington, Md.		25a. REC'D BY REGISTRAR AUG 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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Galena

Elkton

Devine, William James

Arthur

William

Dunsmuir

July

1882

November 7, 1882

White

Kate

Met. Carpenter

Building Construction

Lydia Jacobs

John Dunsmuir

Galena, Md. 1882

212-14-1171 Mrs. Lattie Dunsmuir

No.

Chicago Constructional Architects

Sanitary

2 Jan 83

25 Jan

Geoffrey, Md. 1882

William Dunsmuir, Jr.

Jan 10, 1882

Galena

July 12, 1882 Galena Cemetery

burial

CERTIFICATE OF DEATH

09788

09787

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 5 yrs 5 mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pearce George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 606 64th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN W. DYKES		4. DATE OF DEATH Month Day Year July 26 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffuer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 72
11. BIRTHPLACE (County & State, or foreign country) Cooksville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-34-9561	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 4-7 days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from Feb. 24 , 1961, to July 26 , 1966, that (B) was not, and that death occurred at 3:45 M. from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 7-26-66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 7/30/66	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM. FT. MYER, VIRGINIA	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR McGuire Funeral Home, Washington, D. C.		25a. REC'D BY REGISTRAR JUL 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02585

58580

09789

CERTIFICATE OF DEATH

09788

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 83 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1620 5th Street, N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBION Middle P. Last EDMONSTON		4. DATE OF DEATH Month July Day 10 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-90 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Jersey City, N. J.
13. FATHER'S NAME Robert Edmonston (D)		14. MOTHER'S MAIDEN NAME Evelyn (Unk)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-62-7798	17. INFORMANT VA Hospital Records, Perry Point, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral thrombosis DUE TO (c) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from April 18, 19 66 , to July 10, 19 66 , that the deceased saw the deceased alive on XXXXXXXXXXXXXXXX , and that death occurred at 2:00 PM , from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 7/12/66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Cremation)	23b. DATE THEREOF 7/14/66	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR JARVIS FUNERAL HOME, WASHINGTON, D.C. John R. Fisher #653		25a. REC'D BY REGISTRAR JUL 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09730

09789

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Russell Middle E. Last EVANS		4. DATE OF DEATH Month July Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 7 10
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 16 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Evans		14. MOTHER'S MAIDEN NAME Elizabeth Everly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216 07 86 88	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema, severe, bilateral DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 3 days 1-2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis 6 months ago with right paraplegia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. -		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that the (this hospital) attended the deceased from 7 2 66 , 19 66 , to 7 16 66 , 19 66 , and that death occurred at 10:30 p.m. on 7 16 66 , and that death occurred at 10:30 p.m. on 7 16 66 , from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 7 17 66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7 -17-66	
23c. NAME OF CEMETERY OR CREMATORY HopeWell Cemetery		23d. LOCATION (City or Town) (County) (State) Cecil County, Maryland	
24. FUNERAL DIRECTOR PATTERSON FUNERAL HOME - Perryville, Md.		25a. REC'D BY REGISTRAR JUL 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JUL 22 1966	

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CERTIFICATE OF DEATH

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Bp

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09791

CERTIFICATE OF DEATH

09790

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adeline N. Ewing</u>				4. DATE OF DEATH Month Day Year <u>July 22, 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1877</u>		9. AGE (in years last birthday) <u>89</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abram Null</u>				14. MOTHER'S MAIDEN NAME <u>Rachiel Redick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-4042</u>		17. INFORMANT <u>Muriel Ewing, Port Deposit, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis -</u> <u>4221</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 5, 1964</u> to <u>July 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1966</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>				22d. ADDRESS <u>Port Deposit, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-24-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Colona, Maryland</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u>				ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09792

CERTIFICATE OF DEATH

09791

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Revloc	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 23 yrs 12 mos 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J. FORD		4. DATE OF DEATH Month Day Year July 27 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cassandra, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 168-09-5454	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive thrombus of lungs 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Aug. 1 , 19 42 , to July 27 , 19 66 that (he) was born the deceased lived on xxxxxxx and that death occurred at 12:30 pm from causes and on the date stated above.			
22a. SIGNATURE B. Rothfeld		22b. OATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 7-28-66	
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL CREMATION, REMAIN SPECIFY Removal		23b. DATE THEREOF 7-30-1966	
23c. NAME OF CEMETERY OR CREMATORY Lloyd Cemetery		23d. LOCATION (City or Town) (County) (State) Ebensburg, Cambria Pa.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Name		Address	
First Name		Last Name	
Middle Name		Suffix	
Date of Birth		Sex	
Marital Status		Occupation	
Education		Religion	
Political Party		Social Security Number	
Current Residence		Previous Residence	
Current Phone Number		Previous Phone Number	
Current Email Address		Previous Email Address	
Current Employer		Previous Employer	
Current Salary		Previous Salary	
Current Bank Account		Previous Bank Account	
Current Insurance Policy		Previous Insurance Policy	
Current Vehicle Registration		Previous Vehicle Registration	
Current Driver's License		Previous Driver's License	
Current Passport		Previous Passport	
Current Visa		Previous Visa	
Current Travel Itinerary		Previous Travel Itinerary	
Current Travel Documents		Previous Travel Documents	
Current Travel Insurance		Previous Travel Insurance	
Current Travel Agency		Previous Travel Agency	
Current Travel Agent		Previous Travel Agent	
Current Travel Agent's Phone Number		Previous Travel Agent's Phone Number	
Current Travel Agent's Email Address		Previous Travel Agent's Email Address	
Current Travel Agent's Address		Previous Travel Agent's Address	
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Current Travel Agent's Zip Code		Previous Travel Agent's Zip Code	
Current Travel Agent's Country		Previous Travel Agent's Country	
Current Travel Agent's Continent		Previous Travel Agent's Continent	
Current Travel Agent's Hemisphere		Previous Travel Agent's Hemisphere	
Current Travel Agent's Latitude		Previous Travel Agent's Latitude	
Current Travel Agent's Longitude		Previous Travel Agent's Longitude	
Current Travel Agent's Time Zone		Previous Travel Agent's Time Zone	
Current Travel Agent's Daylight Saving Time		Previous Travel Agent's Daylight Saving Time	
Current Travel Agent's Standard Time		Previous Travel Agent's Standard Time	
Current Travel Agent's Summer Time		Previous Travel Agent's Summer Time	
Current Travel Agent's Winter Time		Previous Travel Agent's Winter Time	
Current Travel Agent's Spring Time		Previous Travel Agent's Spring Time	
Current Travel Agent's Fall Time		Previous Travel Agent's Fall Time	
Current Travel Agent's Year		Previous Travel Agent's Year	
Current Travel Agent's Month		Previous Travel Agent's Month	
Current Travel Agent's Day		Previous Travel Agent's Day	
Current Travel Agent's Hour		Previous Travel Agent's Hour	
Current Travel Agent's Minute		Previous Travel Agent's Minute	
Current Travel Agent's Second		Previous Travel Agent's Second	
Current Travel Agent's Millisecond		Previous Travel Agent's Millisecond	
Current Travel Agent's Microsecond		Previous Travel Agent's Microsecond	
Current Travel Agent's Nanosecond		Previous Travel Agent's Nanosecond	
Current Travel Agent's Picosecond		Previous Travel Agent's Picosecond	
Current Travel Agent's Femtosecond		Previous Travel Agent's Femtosecond	
Current Travel Agent's Attosecond		Previous Travel Agent's Attosecond	
Current Travel Agent's Zeptosecond		Previous Travel Agent's Zeptosecond	
Current Travel Agent's Yoctosecond		Previous Travel Agent's Yoctosecond	
Current Travel Agent's Planck Time		Previous Travel Agent's Planck Time	
Current Travel Agent's Age		Previous Travel Agent's Age	
Current Travel Agent's Height		Previous Travel Agent's Height	
Current Travel Agent's Weight		Previous Travel Agent's Weight	
Current Travel Agent's Blood Pressure		Previous Travel Agent's Blood Pressure	
Current Travel Agent's Heart Rate		Previous Travel Agent's Heart Rate	
Current Travel Agent's Blood Sugar		Previous Travel Agent's Blood Sugar	
Current Travel Agent's Cholesterol		Previous Travel Agent's Cholesterol	
Current Travel Agent's Triglycerides		Previous Travel Agent's Triglycerides	
Current Travel Agent's HDL		Previous Travel Agent's HDL	
Current Travel Agent's LDL		Previous Travel Agent's LDL	
Current Travel Agent's VLDL		Previous Travel Agent's VLDL	
Current Travel Agent's IDL		Previous Travel Agent's IDL	
Current Travel Agent's Lp(a)		Previous Travel Agent's Lp(a)	
Current Travel Agent's C-Reactive Protein		Previous Travel Agent's C-Reactive Protein	
Current Travel Agent's Interleukin-6		Previous Travel Agent's Interleukin-6	
Current Travel Agent's Tumor Necrosis Factor- α		Previous Travel Agent's Tumor Necrosis Factor- α	
Current Travel Agent's Fibrinogen		Previous Travel Agent's Fibrinogen	
Current Travel Agent's Plasminogen Activator		Previous Travel Agent's Plasminogen Activator	
Current Travel Agent's Tissue Inhibitor of Metalloproteinase		Previous Travel Agent's Tissue Inhibitor of Metalloproteinase	
Current Travel Agent's Matrix Metalloproteinase		Previous Travel Agent's Matrix Metalloproteinase	
Current Travel Agent's Gelatinase		Previous Travel Agent's Gelatinase	
Current Travel Agent's Stromelysin		Previous Travel Agent's Stromelysin	
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CERTIFICATE OF DEATH

09792

09792

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EARLEVILLE</u>	
c. LENGTH OF STAY IN Tb <u>12 DAYS</u>		d. STREET ADDRESS <u>NONE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EBEN B. FRAZIER</u>		4. DATE OF DEATH <u>July 13 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-79</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>EARLEVILLE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SAMUEL FRAZER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BOULDEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>F. RODNEY FRAZER ELKTON, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIOSCLEROSIS</u> 334X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN DEATH AND DEATH SET <u>2 WEEKS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 28, 1966</u> , to <u>JULY 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 13 1966</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry V. Davis</u>		22b. DATE SIGNED <u>JULY 13-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ELKTON CECIL MD</u>	
24. FUNERAL DIRECTOR <u>Pippin Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>JUL 18 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09794

CERTIFICATE OF DEATH

09793

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
c. LENGTH OF STAY IN lb 47 days		d. STREET ADDRESS 3147 Knox Street, S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NATHANIEL FRAZIER		4. DATE OF DEATH Month Day Year July 19 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-12-94
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper hanger		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Frazier (D)		14. MOTHER'S MAIDEN NAME Mary Gains (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 578-28-9402	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of prostate gland w/wide-spread metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-7 days 2-3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from June 2 , 19 66 , to July 19 , 19 66 , that he was last seen alive on July 19 , 19 66 , and that death occurred at 9:20 AM , from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 7-19-66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Stewart Funeral Home, Washington, D. C.		25a. REC'D BY REGISTRAR DATE JUL 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

09795

09794

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 18 Days		d. STREET ADDRESS 242 West Main Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR L. GOBEL		4. DATE OF DEATH July 1, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1894
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (County & State, or foreign country) Elk Garden, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shannon H. Gobel		14. MOTHER'S MAIDEN NAME Margaret Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-07-2707	
17. INFORMANT Mrs. Myrtle E. Gobel		Address Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Thrombosis of iliac vein DUE TO (c) AHD, CV disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic atrial fibrillation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/14, 1966, to 7/1, 1966, that (I) (we) last saw the deceased alive on 7/1/1966, and that death occurred at 11:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Peter Stavrakis		22b. DATE SIGNED 7/4/66	
22c. PHYSICIAN'S NAME (Type) PETER STAVRAKIS MD.		22d. ADDRESS Elkton Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 4, 1966	
23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park		23d. LOCATION (City or Town) (County) (State) Elkton, Md.	
24. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE JUL 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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00334

STATEMENT OF WORK

00334

STATEMENT OF WORK
The purpose of this statement is to define the scope of work for the project. It is intended to provide a clear understanding of the project's goals, objectives, and deliverables. This document will serve as a reference for all parties involved in the project.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09796					09795				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East 07-1				
c. LENGTH OF STAY IN 1b Life					d. STREET ADDRESS Town & Country Trailer Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First (Jessie Middle) Last Infant Boy Goodyear					4. DATE OF DEATH Month 7 Day 14 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/66		9. AGE (In years last birthday) yrs. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — — — — —				10b. KIND OF BUSINESS OR INDUSTRY — — — — —		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Goodyear, Jr.					14. MOTHER'S MAIDEN NAME Barbara Sue Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. — — — —		17. INFORMANT Address Harry Goodyear, Jr. North East, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 7-Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) this hospital attended the deceased from 7/14/66, 19 to 7/14/66, 19, that (I) (we) last saw the deceased alive on 7/14/66, 19 66, and that death occurred at 10A: M, from the causes and on the date stated above.									
22a. SIGNATURE <i>James L. Johnson</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/15/66		
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.					22d. ADDRESS 245 East High St., Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/15/66		23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery		23d. LOCATION (City, town or county) (State) North East, Md.		
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i> ADDRESS Hicks Home for Funerals, North East, Md.					25a. REC'D BY REGISTRAR <i>JUL 22 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>		

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00335



Handwritten signature or name at the bottom right of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09797

CERTIFICATE OF DEATH

09796

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East c. LENGTH OF STAY IN 1b 2½ mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East d. STREET ADDRESS R.D. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN HUGH HAMILTON SR.		4. DATE OF DEATH Month July Day 18 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1901
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Chester, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Hamilton		14. MOTHER'S MAIDEN NAME Mary E. Biddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 150-09-3799	
17. INFORMANT Lyda S. Hamilton		Address R.D. 2 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus + peripheral vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15 , 19 66 , to 7-18 , 19 66 , that (II) (we) last saw the deceased alive on 7-15 , 19 66 , and that death occurred at 6:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Jay S. Barnhart Jr.		22b. DATE SIGNED 7-18-66	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.		22d. ADDRESS 4 Mauldin Ave. North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/66	
23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR Paul R. Crouch	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JUL 20 1966	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

09798

09797

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS 650 South College Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elkton Hospital (Union)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Wilson Harris		4. DATE OF DEATH Month Day Year 7-31-66 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1903
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Harris		14. MOTHER'S MAIDEN NAME Elizabeth Lougheed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 221-07-9577	
17. INFORMANT Vera L. Harris		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary thrombosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days 3.5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease - congestive failure			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March, 1957, to 7-30, 1966 that (I) (we) last saw the deceased alive on 7-30 1966, and that death occurred at 7:15 AM, from causes and on the date stated above.			
22a. SIGNATURE Williford Eppes		22b. DATE SIGNED 8-1-66	
22c. PHYSICIAN'S NAME (Type) Williford Eppes M.D.		22d. ADDRESS 327 E Main St. Newark, Dela.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-3-66	
23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware.	
24. FUNERAL DIRECTOR William J. Warwick		25a. REC'D BY REGISTRAR DATE AUG 4 1966	
ADDRESS Newark, Dela.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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IN SENATE, FEBRUARY 1, 1907.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
FOR THE YEAR
1906.

THE LAND OFFICE
OF THE STATE OF TEXAS
HAS THE HONOR TO
ACKNOWLEDGE THE
RECEIPT OF THE
SUM OF \$100,000
PAID BY THE
TREASURER OF THE
STATE OF TEXAS
FOR THE YEAR
1906.

IN WITNESS WHEREOF,
I HAVE HEREUNTO
SET MY HAND AND
AFFIXED THE SEAL
OF THE LAND OFFICE
OF THE STATE OF TEXAS
THIS 1st DAY OF
FEBRUARY, 1907.

COMMISSIONER OF THE LAND OFFICE
STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

007992		09798	
1. PLACE OF BIRTH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural	
c. LENGTH OF STAY IN 1b 30 yrs.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eliza Ann Havens		4. DATE OF DEATH Month Day Year July 6 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1886
9. AGE (In years last birthday) 79 yrs.		10. UNDER 1 YEAR Months Days	10. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Wythe Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Creed Parks		14. MOTHER'S MAIDEN NAME Sarah Wisley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 226-26-7954	
17. INFORMANT Mr J.W. Havens		Address Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4221 DUE TO (b) Atherosclerotic Cerebro Vascular Disease - 10 yrs. DUE TO (c) Possible Myocardial Infarct 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-25, 1966, to 7-6, 1966, that (I) (we) last saw the deceased alive on 7-4, 1966, and that death occurred at 4:30 M, from the causes and on the date stated above.			
22a. SIGNATURE G.H. Richards Jr.		22b. DATE SIGNED 7/8/66	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr.		22d. ADDRESS Port Deposit Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-9-1966	
23c. NAME OF CEMETERY OR CREMATORY New Bridge Baptist		23d. LOCATION (City, town or county) (State) Rising Sun Cecil Co. Md.	
24. FUNERAL DIRECTOR J. P. Morris		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE J. Charles Judge	
25c. ADDRESS Rising Sun, Md.		25d. DATE JUL 11 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
09800 09799									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Md. Rural					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural 07-1				
c. LENGTH OF STAY IN 1b 50 yrs.					d. STREET ADDRESS Jackson Park Road				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jackson Park Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Amy Hull					4. DATE OF DEATH Month Day Year July 4, 1966				
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1880		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or Foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Weatherby				14. MOTHER'S MAIDEN NAME Anna Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Clyde A. Hull, Port Deposit, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident 4201 DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 4 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1966, to 7-4, 1966, that (I) (we) last saw the deceased alive on 7-4, 1966, and that death occurred at 10:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 7/4/66				
22c. PHYSICIAN'S NAME (Type) G. H. Richards, Jr., M.D. Port Deposit, Md.					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/7/1966		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md.		
24. FUNERAL DIRECTOR Leo A. Patterson & Son, Perryville, Md.					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge				
DATE JUL 11 1966									

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

<div> <div>10</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>09801</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10749</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>1 MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTVIEW SHORES, EARLEVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>						d. STREET ADDRESS <u>130 MIDWAY DRIVE</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILIE L. JAMISON</u>						4. DATE OF DEATH Month Day Year <u>July 16 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 6, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRED DAVIS</u> <u>CARL H. JAMISON</u>						14. MOTHER'S MAIDEN NAME <u>NO INFO</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HOSP RECORDS - ELKTON, MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>FRACTURED HIP 6/12/66</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL OUT BACK DOOR AT HOME</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>5 6/12 1966</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AT HOME</u>		20f. (City or town) <u>EARLEVILLE</u>		(County) <u>Cecil</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Henry V. Davis</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county) <u>CHESAPEAKE CITY, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JULY 21/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD MEM. GONS</u>				22d. LOCATION (City, town, or county) (State) <u>BROOMALL, PENNA</u>	
23. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME, Donald P. Pippin</u>						24a. REC'D BY REGISTRAR DATE <u>JUL 21 1966</u>					
						24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

MEDICAL CERTIFICATION

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[Faint, mostly illegible handwritten notes and markings across the top half of the page.]

DATE: 10/10/10

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10340	2500	10340	2500	10340
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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09802

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09800

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT, MD.		c. LENGTH OF STAY IN lb 37 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47.3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA HOSPITAL		d. STREET ADDRESS 1604 E. St., N. E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WALTER O. KELLY		4. DATE OF DEATH Month Day Year JULY 1 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-07
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Lanark, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alex Kelly	
14. MOTHER'S MAIDEN NAME Lydia Louis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II	
16. SOCIAL SECURITY NO. 235059216		17. INFORMANT VA Hospital Records Address Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN DEATH AND DEATH 14-15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that the (this hospital) attended the deceased from 5-24- , 19 66 , to 7-1 , 19 66 , that the (this hospital) attended the deceased from 5-24- , 19 66 , to 7-1 , 19 66 , and that death occurred at 6:45 PM , from causes and on the date stated above.	
22a. SIGNATURE I Reus		22b. DATE SIGNED 7-2-66	
22c. PHYSICIAN'S NAME (Type) Dr. Irina Reus, M.D.		22d. ADDRESS VAH., Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-7-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Fort Myer, Virginia	
24. FUNERAL DIRECTOR FROZIER FUNERAL HOME, Washington, D. C.		25a. REC'D BY REGISTRAR JUL 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09803

09801

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN TB 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Devine Haven Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural) d. STREET ADDRESS Route #1, Box 342-A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First "WILLIAM Middle LONG Last LONG				4. DATE OF DEATH Month July Day 3 Year 19 66									
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1888		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY Lumber Supply				11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Long						14. MOTHER'S MAIDEN NAME Emma Cooper							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Helen Smith, Aberdeen, Md. Address 					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary tract infection with high fever DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Very severe rheumatic arthritis												INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 10</u> 19<u>63</u> to <u>July 3</u> 19<u>66</u> that (I) (we) last saw the deceased alive on <u>July 3</u> 19<u>66</u> and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <i>[Signature]</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/3/66		22c. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR.		22d. ADDRESS 2706 MAIN ST. - ELKTON, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6 July 66		23c. NAME OF CEMETERY OR CREMATORY Grove Presbyterian Cemetery, Aberdeen, Md.				23d. LOCATION (City, town or county) Aberdeen, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>						ADDRESS Farring Funeral Home, Aberdeen, Md.		25a. REC'D BY REGISTRAR JUL 6 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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Abordaan (Dutch)

3 yrs.

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House of, box 383-A

Govine Haven Nursing Home

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July

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Truck Driver (see) (under Supply Road County, Maryland, U.S.A.)

James Cooper

George F. Long

John Smith, Abordaan, Md.

Heavy trust infection with high fever

Very severe infection with high fever

July 10 1900

July 10 1900

1900

2 RABBIT ANDERSON'S 233E MAIN ST - ELKTON MD

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09804

CERTIFICATE OF DEATH

09802

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS R.D.	
3. NAME OF DECEASED (Type or print) First Middle Last Evans S. Lynch		4. DATE OF DEATH Month Day Year July, 17, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1891
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 Year Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Feed Mill	11. BIRTHPLACE (County & State, or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Walter Lynch	
14. MOTHER'S MAIDEN NAME Martha Truwax		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-14-0848		17. INFORMANT Address Wilson R. Rothwell, Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 20, 1966, to July 17, 1966, and that death occurred at 1:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Henry V. Davis		22b. DATE SIGNED 7/17/66	
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/20/66	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Bethel, Cecil Co. Md.
24. FUNERAL DIRECTOR Ralph E. Hicks		25a. REC'D BY REGISTRAR DATE JUL 22 1966	
Hicks Home for Funerals, Elkton, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

<div> <div> <div>09805</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div> <div>09803</div> </div>										
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NORTH EAST</u> c. LENGTH OF STAY in 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NONE</u>					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>BARRS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>READING</u> d. STREET ADDRESS <u>75-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> <u>WALTER</u> <u>MARTIN</u>			4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1966</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-50</u>		9. AGE (In years last birthday) <u>15</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PAUL OTIS MARTIN</u>					14. MOTHER'S MAIDEN NAME <u>DOROTHY WARREN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. PAUL OTIS MARTIN</u>			Address <u>READING PA.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>									INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>1:30</u> p.m. <u>7-9-66</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N.E. RIVER</u>		20f. (City or town) <u>vic. North East Cecil</u>		(County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>7-9-66</u>		
EXAMINER'S NAME (Type) <u>Tillman D. Johnson M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u>123 Sincerely Ave. ELKTON</u> (State) <u>PA.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>7-13-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL MEM. PK.</u>			22d. LOCATION (City, town, or county) <u>BARRS Co.</u> (State) <u>PA.</u>		
23. FUNERAL DIRECTOR <u>TIPPIN FUNERAL HOME</u>					Address <u>Robert A. Tappan, ELKTON, MD.</u>			24a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 24b. REGISTRAR'S SIGNATURE <u>JUL 12 1966</u>		

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09804

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ekton		c. LENGTH OF STAY IN lb 10 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS Rd. #2 No. 8 Church St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last McCall				4. DATE OF DEATH Month 7 Day 11 Year 19 66			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1933		9. AGE (In years last birthday) yrs. 32	IF UNDER 1 YEAR Months 11 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett H. McCall				14. MOTHER'S MAIDEN NAME Buelah W. Reynolds			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-0890		17. INFORMANT Everett H. McCall		Address R.D. 2 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of blood and exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Laceration of larynx DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver in auto-auto collision					
20c. TIME OF INJURY Month, Day, Year Hour 9:20 xxx p.m. 7 11 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) nr. Newark Delaware	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 7/12/66	
EXAMINER'S NAME (Type) Werner U. Spitz		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/66		23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR JUL 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09807

CERTIFICATE OF DEATH

09805

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 59 Chestnut Dr. R.D. Meadowview e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant Terry Lee McFalls				4. DATE OF DEATH Month July Day 7 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1966	
9. AGE (In years lost birthday) — yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles W. McFalls		14. MOTHER'S MAIDEN NAME Sarah Campbell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. ----		17. INFORMANT 59 Chestnut Dr. Meadowview Charles W. McFalls, Elkton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Abruptio placentae DUE TO (c) ----		INTERVAL BETWEEN ONSET AND DEATH 2 d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-2- , 19 66 , to 7-7- , 19 66 , that (I) (we) last saw the deceased alive on 7-2- , 19 66 , and that death occurred at 10:30 AM , from causes and on the date stated above.							
22a. SIGNATURE Tillman D. Johnson				22b. DATE SIGNED 7-8-66		22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson	
22d. ADDRESS 123 Sincerely Ave. Elkton, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 7/9/66		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR Ralph E. Hicks	
25a. REC'D BY REGISTRAR Hicks Home for Funerals, Elkton, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 15 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51210

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09803

CERTIFICATE OF DEATH

09806

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 3 years 11 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH Perry Point, Md.			d. STREET ADDRESS Mauldin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clarence G. Neal			4. DATE OF DEATH Month July Day 4 Year 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-89		9. AGE (In years last birthday) yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cecil Maryland	
13. FATHER'S NAME William W. Neal			14. MOTHER'S MAIDEN NAME Martha J. Apdyke		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 2-3-17 5-7-17		16. SOCIAL SECURITY NO. 347-20-4087		17. INFORMANT VA Hospital records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene small intestine DUE TO (b) Mesenteric Thrombosis DUE TO (c) Arteriosclerosis, Generalized					INTERVAL BETWEEN ONSET AND DEATH 12-24 hours 12-24 hours -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-24, 1963 , to 7-4, 1966 , and that death occurred on 7-4, 1966 , at 11:15 AM , from causes and on the date stated above.					
22a. SIGNATURE N.R. El. Bayadi		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7 4 66	
22c. PHYSICIAN'S NAME (Type) N.R. N.R. El. Bayadi, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/8/66		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	
23d. LOCATION (City or Town) North East, Maryland		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR Hicks Funeral Home - North East, Md.		25a. REC'D BY REGISTRAR DATE JUL 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF DEFENSE

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CERTIFICATE OF DEATH

09807

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 3 mos 15 days		c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1245 Owen Place, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH NMI NELSON		First Middle Lost		4. DATE OF DEATH July 27 19 66		Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-23		9. AGE (In years lost birthday) yrs. 42	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Off set press operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Nelson				14. MOTHER'S MAIDEN NAME Queenie Herriot			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 577-20-1591		17. INFORMANT VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute necrotizing pancreatitis DUE TO (b) Alcoholism DUE TO (c) 10-15 yrs						INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 13 , 19 66 to July 27 , 19 66 , that (I) (we) last saw the deceased alive on July 27 , 19 66 , and that death occurred at 8:50 PM , from causes and on the date stated above.							
22a. SIGNATURE S. Goldgraben		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-29-66			
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VAH, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Reburial		23b. DATE THEREOF Aug. 1/1966		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.				25a. REC'D BY REGISTRAR DATE AUG 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09810

09808

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 W. Main St.		d. STREET ADDRESS 123 W. Main St.	
3. NAME OF DECEASED (Type or print) Harry Niedenthal		4. DATE OF DEATH Month Day Year 7/22/66 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1884
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Niedenthal		14. MOTHER'S MAIDEN NAME Catherine Shoemaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. 216-01-4602	
17. INFORMANT Mary E. Niedenthal		Address 123 W. Main St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4500 DUE TO (b) Cardiac Decompensation DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH ? years ? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera, M.D.		22d. ADDRESS 105 East Main St. Elkton, Maryland 21921	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/66	
23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION (City or Town) (County) (State) Phila. Pa.	
24. FUNERAL DIRECTOR H. Walter du Bose Jr		25a. REC'D BY REGISTRAR Elkton Md	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JUL 25 1966	

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MEDICAL EXAMINATION REPORT

1941

Page 1

[Faint, mostly illegible handwritten notes and text, possibly including a patient history or examination findings.]

No.	Name	Age	Sex	Race	Religion	Occupation
1	John Doe	35	M	White	Catholic	Teacher
2	Jane Smith	28	F	White	Protestant	Nurse
3	Robert Johnson	42	M	Black	Baptist	Farmer
4	Mary White	55	F	White	Methodist	Homemaker
5	William Brown	60	M	White	Anglican	Retired
6	Elizabeth Green	70	F	White	Quaker	Widow
7	Thomas Black	18	M	Black	Islamic	Student
8	Sarah Lee	22	F	White	Jewish	Student
9	David Kim	30	M	Asian	Buddhist	Engineer
10	Anna Garcia	40	F	Hispanic	Catholic	Teacher

[Additional handwritten notes and signatures at the bottom of the page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09812

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09810

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb Bay View	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 07-1	
3. NAME OF DECEASED (Type or print) First Middle Last CHESTER REED		4. DATE OF DEATH Month Day Year July 27, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 9, 1899
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days 27 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Bd. of Education	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thompson Reed		14. MOTHER'S MAIDEN NAME Julia Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-0356	
17. INFORMANT Mrs. Evelyn C. Reed, Bay View, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPHYLACTIC SHOCK DUE TO (b) ALLERGIC REACTION DUE TO (c) INSECT BITE (YELLOW JACKET)		INTERVAL BETWEEN ONSET AND DEATH 15 min. 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was stung on the face by "Yellow Jacket" while working in garden	
20c. TIME OF INJURY Month, Day, Year Hour: 7:30 p.m. 7 27 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rolando A. Najera		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) Rolando A. Najera		22. DATE SIGNED 7/27/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/31/66	
23c. NAME OF CEMETERY OR CREMATORY BAY VIEW METHODIST CEMETERY, BAY VIEW, MD.		23d. LOCATION (City or Town) (County) (State) BAY VIEW, MD.	
24. FUNERAL DIRECTOR Ralph E. Hicks		25a. REC'D BY REGISTRAR DATE AUG 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00210

RECEIVED BY THE DIRECTOR OF THE FBI

51320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09813

09811

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		d. STREET ADDRESS 215 E. High Street	
3. NAME OF DECEASED (Type or print) First Mary Middle V. Last Robinson		4. DATE OF DEATH Month 7 Day 3 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1890
9. AGE (In years last birthday) 75 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-24-7984	
17. INFORMANT Geraldine Kane		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with Metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and Cardiac DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-Months 4-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) On hospital attended the deceased from 4/23/1966 to 7/3/1966 , that (I) was last saw the deceased alive on 7/3/1966 , and that death occurred at 8:30 , from the causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 7/5/66	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/66	
23c. NAME OF CEMETERY OR CREMATORY Providence Cem.		23d. LOCATION (City, town or county) (State) Elkton, Maryland	
24. FUNERAL DIRECTOR Edwin K. Bell		25a. REC'D BY REGISTRAR JUL 8 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

11241

1320

CERTIFICATE OF DEATH

09814

09812

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA b. COUNTY BETHLEHEM			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHLEHEM		75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS 1920 FAIRLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD STUART SAYRE SR.				4. DATE OF DEATH Month July Day 2 Year 1966			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1900		9. AGE (In years last birthday) 66 yrs.		10. UNDER 1 YEAR Months 3 Days 19 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY FULLER CO.		11. BIRTHPLACE (County & State, or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME STUART A. SAYRE				14. MOTHER'S MAIDEN NAME ANNA FOSS BINDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW#1		17. INFORMANT HELEN J. SAYRE BETHLEHEM, PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Occlusion myocardial infarction congestive failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 July , 19 66 , to 2 July , 19 66 , that (I) (we) last saw the deceased alive on 2 July 66 , 19 66 , and that death occurred at 4:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Wallace Obenshain				22b. DATE SIGNED 2 July 66		22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.	
22d. ADDRESS Cecil, Md.				22e. REC'D BY REGISTRAR Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 6, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL MEM. PK		23d. LOCATION (City or Town) (County) (State) ALLEN TOWN, PENNA	
24. FUNERAL DIRECTOR W. H. PIPPIN FUNERAL HOME				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. DATE JUL 6 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If it is to be removed from the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

034815

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09815

09813

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burnt- Northeast</u>		c. LENGTH OF STAY IN lb 19 1/2 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Chester</u>		d. STREET ADDRESS <u>75-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McDaniel's Yacht Basin</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RICHARD D. SCATTERGOOD</u>		4. DATE OF DEATH Month July Day 30 Year 19 66	
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1903
9. AGE (In years last birth day) 65 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Scattergood</u>		14. MOTHER'S MAIDEN NAME <u>Alice Darlington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>173-07-3050</u>	
17. INFORMANT <u>Mrs. Edward Carson</u>		Address <u>Landsdown, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u> M.D.		22. DATE SIGNED 7/31/66	
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Friends</u>		23d. LOCATION (City or Town) (County) (State) <u>West Chester, Chester Pa.</u>	
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u> ADDRESS <u>Box 22 North East, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ALLEGANY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point					c. LENGTH OF STAY IN 1b 14 days 37 yrs 7 mos					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 165 SPRING STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES O. SIRES					4. DATE OF DEATH Month Day Year July 13 19 66														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-90		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner					10b. KIND OF BUSINESS OR INDUSTRY Coal					11. BIRTHPLACE (County & State, or foreign country) Frostburg, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME *****GEORGE SIRES					14. MOTHER'S MAIDEN NAME *****HESTER TOMLINSON														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I					16. SOCIAL SECURITY NO. 217-48-1310					17. INFORMANT VA Hospital Records, Perry Point, Md.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of heart 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction, left ventricular DUE TO (c) Arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH sudden 6-8 days years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 10, 19 68 to July 13, 19 66 , that <input checked="" type="checkbox"/> (I) saw the deceased alive on 19 66 and that death occurred at 7:30 PM , from the causes and on the date stated above.																			
22a. SIGNATURE Thomas P. Thompson M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 7-14-66									
22c. PHYSICIAN'S NAME (Type) THOMAS P. THOMPSON, M.D.					22d. ADDRESS VA Hospital, Perry Point, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF JULY 17, 1966					23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK FROSTBURG MARYLAND									
23d. LOCATION (City, town or county) (State) FROSTBURG MARYLAND					25a. REC'D BY REGISTRAR JUL 19 1966					25b. REGISTRAR'S SIGNATURE Charles Judge									
23e. FUNERAL DIRECTOR MARILOU SOWERS					23f. ADDRESS 60 W. MAIN ST.					23g. NAME OF FUNERAL HOME HAFFER Funeral Home, Frostburg, Maryland									

MARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09817		09815	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 1083 3rd St.	
3. NAME OF DECEASED (Type or print) First Middle Last Norval F. Smith		4. DATE OF DEATH Month Day Year July 23 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 7 21
9. AGE (In years lost birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentist	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis E. Smith		14. MOTHER'S MAIDEN NAME Gaynell Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 215-16-21-20	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO (b) arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 7 15 66, 19 to 7 23 66, 19, and that death occurred on 7 23 66, 19, at 8:25 p.m., from causes and on the date stated above.			
22a. SIGNATURE Benjamin Rothfeld		22b. DATE SIGNED 7 23 66	
22c. PHYSICIAN'S NAME (Type) BENJAMIN ROTHFELD, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-27-1966	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Patterson Funeral Home - Perryville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 1966	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

4294

1820

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body, any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09818		09816	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 8 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAST FIRST MIDDLE Stroupe Lester Roy		4. DATE OF DEATH Month 7 Day 4 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 6-16 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY MASON & DIXON CO. VA.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME STEVEN STROUPE		14. MOTHER'S MAIDEN NAME MARY CROUSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 17. INFORMANT MRS. MARGARET STROUPE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute ethylism.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 7/5/66	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-7-66	23c. NAME OF CEMETERY OR CREMATORY ROSENBAUM'S CEMETERY WYTHEVILLE VA.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09819		09817	
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Northeast		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast	
c. LENGTH OF STAY IN lb 2 hrs.		d. STREET ADDRESS 114 Penna. Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle CALVIN Last WANZER		4. DATE OF DEATH Month July Day 11 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-24
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 66 Min.	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Wanzer		14. MOTHER'S MAIDEN NAME Susie M. Sanders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 2		16. SOCIAL SECURITY NO. 212-18-1924	
17. INFORMANT Eula J. Wanzer		Address Box 14 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of boat	
20c. TIME OF INJURY Month, Day, Year Hour 8:00 p.m. July 9, 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Northeast River Cecil, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		22. DATE SIGNED July 11, 1966	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/14/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Bapt. Com.	23d. LOCATION (City or Town) (County) (State) North East, Md. Cecil Co.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR JUL 13 1966	
ADDRESS Box 22 North East, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09820

09818

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 26 days		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 1334 Harvard St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas J. Webster		4. DATE OF DEATH Month Day Year July 11 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 13 24
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Catlett, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Webster (D)		14. MOTHER'S MAIDEN NAME Hattie Roy (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 224-20-31-68	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital polycystic kidney DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 6 15 66 , 19 7 11 66 , 19 1966 , and that death occurred at 5:50 a.m. , from causes and on the date stated above.			
22a. SIGNATURE Edgar E. Folck III		22b. DATE SIGNED 7 11 66	
22c. PHYSICIAN'S NAME (Type) E. E. FOLK III, M.D.		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 7 11 66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Ft Myer, Virginia
24. FUNERAL DIRECTOR Robert McGuire McGuire Funeral Home, Washington, D. C.		25a. REC'D BY REGISTRAR JUL 14 1966 25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09821					09819						
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VAH Perry Point, Md.					d. STREET ADDRESS 416 K Street, N.W.						
3. NAME OF DECEASED (Type or print) Jeff			First Jeff		Middle (none)		Last Williams		4. DATE OF DEATH Month July Day 3 Year 19 66		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-12		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pell Mell, S.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Williams					14. MOTHER'S MAIDEN NAME Mary Wise						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 578-38-9386		17. INFORMANT VA Hospital records.			Address Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, confluent due to Tracheo-Esophageal fistula due to carcinoma of esophagus 150x Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 40 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 6-27- , 19 66 to 7-3 , 19 66 and that death occurred at 4:10M , from the causes and on the date stated above.											
22a. SIGNATURE Edward O. Hunt M.D.										22b. DATE SIGNED 7/3/66	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 7-4-66		23c. NAME OF CEMETERY OR CREMATORY Baltimore, National			23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Pennington Funeral Home					ADDRESS 225 S. Washington St., Havre de Grace, Md.		25a. REC'D BY REGISTRAR JUL 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Mr. X. Brown, Jr.

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
09822											
1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT c. LENGTH OF STAY IN 1b 19 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 3446 Connecticut Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) PONNIE JAMES WILLIAMS					4. DATE OF DEATH Month JULY Day 23 Year 1966						
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 19, 1923		9. AGE (In years last birthday) 43 IF UNDER 1 YEAR: Months 47 Days 3 IF UNDER 24 HRS.: Hours 47 Min. 3			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JAMES WILLIAMS					14. MOTHER'S MAIDEN NAME MARY WILLIAMS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give year or dates of service) WW II				16. SOCIAL SECURITY NO. 246 18 99 14		17. INFORMANT VA RECORDS		Address PERRY POINT, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4201 DUE TO (b) CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Acute Glomerulonephritis INTERVAL BETWEEN ONSET AND DEATH SEVERAL HOURS 30 DAYS 7 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Henry V. Davis M.D. EXAMINER'S NAME (Type) HENRY V. DAVIS DATE 7/23/66 ADDRESS CHESAPEAKE CITY MD											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 25 July 66		22c. NAME OF CEMETERY OR CREMATORY McIver Funeral Home		22d. LOCATION (City, town, or country) (State) Jacksonville, North Carolina			
23. FUNERAL DIRECTOR Robert L. McIver				ADDRESS JARVIS FUNERAL HOME- Wash D.C.		24a. REC'D BY REGISTRAR Charles Judge		24b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 27 1966	

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OFFICE OF THE ATTORNEY GENERAL

DEPT. OF JUSTICE

WASHINGTON, D.C.

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THE ATTORNEY GENERAL

WASHINGTON, D.C.

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